TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PAIN AND RECOVERY CLINIC

Respondent Name
GREAT MIDWEST INSURANCE CO

MFDR Tracking Number
M4-17-1480-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JANUARY 18, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our Facility has been having difficulties with the above carrier in processing these authorized services which were denied for fee schedule allowance."

Amount in Dispute: $375.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill list 180 minutes as the units. Carrier issued reimbursement for 3 hours at the MAR amount of $125 per hour for a total of $375. No additional reimbursement is owed."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 11, 2016	Chronic Pain Management Program CPT Code 97799-CP-CA (6 hours)	$375.00	$375.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12-Workers compensation jurisdictional fee schedule adjustment.
   - 309-The charge for this procedure exceeds the fee schedule allowance.
   - 193-Original payment decision is being maintained. Upon reconsideration it was determined that the original decision was correct.

Issues

Is the requestor entitled to additional reimbursement for the chronic pain management program rendered on November 11, 2016?

Findings

According to the explanation of benefits, the respondent paid $375.00 for the chronic pain management program rendered on November 11, 2016. The respondent contends that no additional reimbursement is due because the requestor billed for "180 minutes as the units. Carrier issued reimbursement for 3 hours at the MAR." A review of the submitted medical bills finds that the requestor billed for six (6) not three (3) hours. The respondent did not submit any documentation to support that only three (3) hours were billed; therefore, the requestor is due additional reimbursement for three hours of chronic pain management program.

28 Texas Administrative Code §134.204(h)(1)(A) states "(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR."

28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The Division finds that the requestor billed CPT code 97799-CP-CA for 6 hours on the disputed date of service. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (5)(A) and (B), the MAR for a CARF accredited program is $125.00 per hour x 6 = $750.00. The respondent paid $375.00. The difference between the MAR and amount paid is $375.00. This amount is recommended for additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $375.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $375.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	2/16/2017 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812